STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145895	A. BUILDING ______ B. WING ______	03/18/2008

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F 444	Continued From page 41 On 3/11/08 at 1:00 PM, E9 stated, "I wash my hands before and after toileting residents". E9 asked about washing hands after taking R21 to the toilet, and stated, "No, I should have washed my hands when I was done with R21". The facility handwashing policy states, "Handwashing is to be done before and after every contact with a resident, after handling of or touching contaminated articles or equipment, before or after eating, after using the bathroom, after any activity involving contact with body secretions and after removing gloves."	F 444		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.1220b)3) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to	F9999		

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F9999	Continued From page 42 assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to identify an environmental hazard on 3/11/08. A closed knife was observed on a bookshelf in R20's room on 3/11/08. R20's room is located on the Willows Unit (Alzheimer's unit) in an area with vulnerable residents (due to cognitive abilities and/or mood/behavior problems). The facility failed to have ongoing assessments to identify when elements in the environment pose hazards to a	F9999		

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F9999	Continued From page 43 particular resident. The facility failed to have consistent monitoring of residents rooms to ensure the safety of residents. The facility failed to ensure the interventions for safety on R20's care plan were implemented. This applies to 1 of 20 residents on the Alzheimer's Unit (R20) who was identified as a possible harm to herself and others. Findings include: R20's behavior problem assessment dated 5/8/07 showed, "R20 has had some real issues this last quarter. Behaviors are spasmodic, R20 is on psychotropic mediations...." R20's care plan list with the assessment dated 5/8/07 showed, "Depression has increased over the past few days. Attempting to leave the unit. Potential elopement risk. Has removed code alert in the past. Potential for injury to self." R20's nurses notes dated 6/1/07 through 6/30/07 were reviewed and included the following entries: -6/8/07 (0900), States she doesn't want to go on. -6/11/07 (1630), Res (resident) still crying and unable to complete sentences. Res does state she "does not want to live anymore." -6/21/07 (1630), Res went out South wing door and became combative c (with) staff when they tried to direct her back to Willows unit, hitting, kicking and trying to hit staff with cane. -6/27/07 (1815), Continuing 1:1 and now res attempts to hide scissors under her legs. Res now combative c (with) nurse and CNA. Removed the scissors from res and another pair from her room. Res continues c (with) increased agitation and combativeness. -6/28/07 (0900) Res came to D/R (dining room)	F9999		

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this AM and then left s (without) eating. CNA then went to res room and res stated to CNA she was not going to eat this AM due to trying to kill herself last noc (night) on PM's."

The nurse practitioner's note for R20 dated 6/28/07 showed, "This is a 79 year old female who was seen today per staff request for increased depression, confusion and agitation. R20 does have a long history of depression. R20 was started on Cymbalta on 6/23/07. Last night R20 required an injection of Haldol due to combativeness and agitation. Assessment and Plan: Depression. Continue with Cymbalta and monitor effectiveness."

The nurse practitioner's note for R20 dated 7/12/07 showed, "R20 has a long history of depression, anxiety and agitation. Due to her depression and dementia, R20 is on Ativan and Seroquel. After talking with staff, I did discover that this week has been a roller coaster for her - periods of crying and periods of happiness. Depression. Unstable. Will continue current medication."

An incident report dated 7/17/07 for R20 showed, "R20 has a history and diagnosis of depression with increasing dementia. R20 has been residing on the Alzheimer Unit due to the need for supervision to prevent elopement. R20 occasionally does needle type craft work in her room as the other residents disturb her. On 7/17/07 at 10:30am, R20 requested scissors which were given to her. She was observed doing craft work in her room throughout the day. At 4:00pm, R20 was in the dining/living area talking to the nurse. R20 became upset because she thought there was a party and she was being

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F9999	Continued From page 45 ignored. The nurse was unable to redirect her. R20 left the living area and went to her room. At 4:10pm, R20 came to the dining room with her left hand over a basin bleeding from a wound on top of left hand. The scissors were in the basin. R20 was sent to the hospital and returned with 13 sutures on top of left hand." The hospital crisis worker's notes for R20 dated 7/17/07 showed, "Earlier this evening, R20 took a pair of scissors and cut her left hand and stitches were required.... R20 has a history of being treated for psychiatric problems, treated for depression. R20 has been inpatient at psychiatric hospitals several times. R20 presents herself as not always alert and oriented as she presents with confusion and thoughts are not always organized. Also presents herself as being severely depressed and very anxious. Diagnosis: Axis I: Dementia with Depressed Mood.; Axis I: Major Depressive Disorder, Severe.; Axis I: Anxiety Disorder, NOS recurrent.; Plan: Follow through with her scheduled appointment with psychiatrist. Continue to closely monitor for moods and behavior. Check her room every day for scissors or other sharp objects she might use to harm herself. recommend R20's psychotropic medications be reviewed to see if they are appropriate." R20's care plan dated 7/18/07 showed, "Problem: Potential for injury to self - 7/18/07: R20 cut self with scissors. Approaches: If she requests to work on craft projects she is to sit at dining room table under direct supervision of staff and is only to use safety scissors. She is not to leave dining area with scissors. Remove potential harmful objects from room, hallway, etc."	F9999		

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F9999	Continued From page 46 R20's nurses notes from 8/11/07 to 3/11/08 were reviewed and documented a number of times that R20 was crying uncontrollably, crying or tearful. Some specific notes include: - 8/11/07 (1435), Resident - confused - extremely agitated. At nurses station crying saying "they are kicking me out. I am leaving. I might as well hurt myself." -12/30/07 (1510), Res (resident) at nurse's station crying c (with) staff wanting to go home. 1-1 done with res - wanting go home. c/o (complains of) no one comes to see her - she should throw herself in a snow drift be an easy way to die. -3/2/08 (1215) Res (resident) very upset. Res states she wants to walk alone but we won't let her. Encouraged res to talk about it. Nurse gently reminded res of unsteadiness & pas falls. Res stated that she does not care. Res also upset because she is still here. Res stood up out of chair (recliner). Clip alarm was not attached to res. Res states that she removed "that thing." This nurse visually saw alarm attached to res a few min earlier. CNA reached res & began to walk c (with) res. CNA attempted to put TB (transfer belt) around res waist. Res resistive saying "no" & pushing at CNA. Walked to exit door (west Willows door). Res insistent on going out door. Nurse intervened. Res pushing at CNA & Nurse while stepping out door. Insistent on walking outside. CNA & Nurse walked resident around corner of building and back into South door in Willows. Res then was compliant c (with) coming back into building. Res then began to push at staff again especially CNA. Nurse tod CNA I would stay with res. Res then ambulated down the hallway towards the south wing. R20 angry.... Res then walked out willows	F9999		

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F9999	Continued From page 47 door leading to the south wing. Nurse followed behind res as close as res would allow. Walked to east door on south wing (door that leads to parking lot). Res pushed the door but door did not open. Res stood there looking out the window & stated, "I'm going to get out of here today & I hope that I freeze to death tonight." Also stated that no one cares.... Gait is unsteady per usual. A few times res lost balance but was able to right self without falling. Res then walked into her room and sat on bed. Res getting angrier c (with) nurse so CNA intervened R20 then laid on the bed a few minutes then stood up and went to closet. Began looking through clothes stating that she had to find some clothes to take with her.... Crying is uncontrollable at times. R20 continues to tell nurse that no one cares anymore and that there is no reason to go on." On 3/11/08 at 10:50am a closed knife was noted laying on the bottom shelf of R20's book shelf in her room. E13 (Registered Nurse/Charge Nurse) and Z3 (Nurse Practitioner) were asked to come to R20's room. E13 confirmed there was a knife on the bottom shelf of R20's book shelf. Z3 was asked about R20's status. Z3 stated, "R20 has severe depression." Z3 was asked if R20 is a danger to herself and others. Z3 stated, "Yes, she can be." Z3 was asked if it would be okay for R20 to have a knife. Z3 stated, "No." A 33 fluid ounce bottle of wrinkle releaser with a warning label to keep out of reach of children was also in R20's room on the floor next to her bed. On 3/11/08 at 11:12am, E25 (Rehabilitation Registered Nurse) stated R20's coordination was "pretty good" and that R20 had good fine motor skills to her upper body. E25 stated R20 is able	F9999		

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to follow simple directions but safety awareness is a concern because R20 thinks she can do more than she can safely do. E25 stated R20 exhibits behaviors of being tearful, anxious and restless.

On 3/11/08 at 11:55am, E26 (Housekeeping Supervisor) was asked about the cleaning of resident rooms on the Willows unit. E26 stated, "Different people clean it every day. They clean under beds. Clean furniture off...." E26 was asked if housekeeping would clean a bookcase with a cloth over it. E26 stated, "No, not unless I told them to. It wouldn't be something they normally do. I didn't know R20 had a sheet over her bookcase."

On 3/11/08 at 12:05pm, E13 (RN) stated the covering over R20's shelf has been there, "Quite a while. R20 likes to keep things private. It's been there a couple of months." E13 was asked how often is R20's room checked. E13 stated, "Every few days. We have to be careful how we put R20's stuff back or she will realize we have been there."

On 3/11/08 at 12:30pm, R20 was observed sitting in a recliner in the lounge. A tab alarm was in place to the chair and R20's left shoulder. R20 stated, "I used to walk now they don't let me." R20 was asked what the tab alarm (resident was touching the string and clip on the alarm) was for. R20 stated, "Anytime I want something I pull this. I have to wait for someone to come. If they were not here I could get it myself "(book on bookshelf). R20 was asked if she had a knife in her room. R20 stated, "No." R20 was asked if she cut herself with scissors. R20 stated, "One time years ago. I had a low period in my life and I

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went to the kitchen and grabbed a silver thing, a knife and I cut my wrist and arm. I didn't have anyone fix it."

On 3/11/08 at 11:45, Z2 (R20's son) was asked if R20 had hurt herself in the past. R20 stated, "About 1.5 years ago R20 used a razor blade on her wrist. R20 does not want to live anymore. I don't see R20 hurting anybody. It wouldn't surprise me if I got a call that she stabbed herself. R20 would hurt herself. R20 has always been very emotional. It puzzles me how R20 got a knife."

The facility's policy and procedure for monitoring residents showed, "Suicidal Ideation - Place resident on behavior tracking, and identify behavior on care plans and write appropriate interventions. Track residents until seen by a psychiatrist/psychologist until ordered that they are no longer a danger to self or others.; Physical Threat - When a resident is observed being physically aggressive make an attempt to move resident from stressful situation. Make sure behavior is identified on care plans and appropriate interventions are followed."

R20's behavior tracking sheets for February 2008 showed the following behaviors: "Refuses to eat. Isolates self. Verbal abuse. Attempts to leave. Talk of harming self. " There were no behaviors noted on the tracking sheet for R20 this month.

R20's nurses notes from 2/1/08 through 2/29/08 showed, "Angry but didn't know why. Refused breakfast. Refused to get up. Laying on bed sobbing. Just upset with her whole life and does not know what to do. States another resident is going to harm her in a sexual manner."